

GENERAL APPENDIX 10

PROVIDER FORMS REQUEST INSTRUCTIONS

=The Department of Public Aid provides required billing forms (with the exception of the UB-92 claim form), prior approval request forms, adjustment forms and various types of pre-addressed mailing envelopes to be used by the providers to submit claims and adjustments to the Department. Single sheet billing forms are intended for use only in laser printers. Multi-page continuous feed forms are intended for use in either typewriters or impact printers.

These materials may only be obtained by submitting Form DPA 1517/1517A, Provider Forms Request, to the Department as described below. The Department will not mail forms (except Form DPA 1517/1517A) in response to telephone requests. Local Department of Human Services offices do not maintain a supply. The provider should submit the Provider Forms Request at least three weeks in advance.

Supplies of either Form DPA 1517 or 1517A may be obtained by calling the appropriate numbers below:

For the counties of Cook, DuPage, Kane, Kankakee, Lake, Will and Winnebago, Form DPA 1517A may be obtained by calling (773) 650-7311.

For all other Illinois counties and all out-of-state providers, Form DPA 1517 may be obtained by calling (217) 786-6968.

PREPARATION AND MAILING INSTRUCTIONS FORM DPA 1517/1517A, PROVIDER FORMS REQUEST

Facsimiles of Form DPA 1517 and 1517A are included in this Appendix. Instructions for their completion follow in the order in which the entry fields appear on the form. The forms should be either typewritten or legibly hand printed.

Provider Name, Provider Number, and Provider Type - Enter the provider name, provider number and provider type exactly as they appear on the Provider Information Sheet.

IDPA Form Number and Quantity - Enter the IDPA form number(s) being requested. Generally, the form number is shown in the lower left corner of the form. In most cases, the form number format will be "DPA" followed by a number or number/alphabetical combination.

Enter the quantity of each form requested. The quantity should be in lots of 100, i.e., 100, 200, 500, etc. Please request a sufficient quantity to last three (3) months. If applicable, indicate whether the forms are to be either Continuous Feed or Snap Out.

IDPA Envelope Number and Quantity - Enter the IDPA envelope number being requested. The number of the envelope is shown in the lower left corner on the face of the envelope. Enter the quantity of the envelope requested. Please request a sufficient quantity to last three (3) months.

Refer to Chapter 200 of the applicable provider Handbook for the form and envelope numbers appropriate for each provider type.

Mailing Label Area (bottom of the form)

Enter the name and address to which forms and envelopes are to be sent. Inclusion of the zip code is essential. Forms and mailing envelopes will be sent only to enrolled providers. The Department of Public Aid will not provide forms or envelopes to a billing service, unless the order includes the name and provider number of a currently enrolled medical provider on whose behalf the billing service is requesting forms.

SUBMITTAL INSTRUCTIONS

Submit the original Provider Forms Request as follows:

For the counties of Cook, DuPage, Kane, Kankakee, Lake, Will and Winnebago send a Form DPA 1517A to:

= Illinois Department of Human Services
Quad County Stores
5150 West Roosevelt Road
Chicago, Illinois 60644-1437
Telephone: (773) 854-5164

For all other Illinois counties and all out-of-state providers, send a Form DPA 1517 to:

= Illinois Department of Human Services
Downstate Stores
5000 Industrial Drive
Springfield, Illinois 62703-5387
Telephone: (217) 786-6968

Questions regarding the correct completion of the Form DPA 1517 or 1517A should be directed to the appropriate phone numbers as shown above.

Reduced Facsimile of Form DPA 1517

DPA 1517 (R-3-95)

PROVIDER FORMS REQUEST



Illinois Department of Public Aid
 5000 INDUSTRIAL DRIVE
 SPRINGFIELD, ILLINOIS 62703-5387

Completion of this form or compliance with instructions is voluntary. However, failure to do so may affect this Department's action on this request. This form approved by the Forms Management Center

Please limit the quantity of forms and envelopes requested to a 3 month's supply.

TYPE OR PRINT ALL ENTRIES.

PROVIDER NAME _____

PROVIDER NUMBER _____ **PROVIDER TYPE** _____

Enter below the "IDPA FORM NUMBER"
AND "QUANTITY" requested.

IDPA FORM NUMBER QUANTITY

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Enter below the "IDPA ENVELOPE NUMBER"
AND "QUANTITY" requested.

IDPA ENVELOPE NUMBER QUANTITY

_____	_____
_____	_____
_____	_____
_____	_____

FOR IDPA USE ONLY

(PROVIDER NUMBER IS REQUIRED)

PROVIDER NUMBER _____ **PROVIDER TYPE** _____

Attention

PROVIDER NAME _____

STREET ADDRESS (cannot deliver to Post Office box)

CITY

STATE

ZIP

Reduced Facsimile of Form DPA 1517A

DPA 1517A (R-5-99)

IL478-203

PROVIDER FORMS REQUEST



Illinois Department of Public Aid
3721 South St. Louis Avenue
Chicago, Illinois 60632-3320

Completion of this form or compliance with instructions is voluntary. However, failure to do so may affect this Department's action on this request. This form approved by the Forms Management Center

Please limit the quantity of forms and envelopes requested to an amount which would be used in a 3 month period.

TYPE OR PRINT ALL ENTRIES

ORDER REQUEST DATE _____

PROVIDER NAME _____

PROVIDER NUMBER _____ PROVIDER TYPE _____

Enter below the "IDPA Form Number"
 And "Quantity" requested.

<u>IDPA Form Number</u>	<u>QUANTITY</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Enter below the "IDPA Envelope Number"
 And "Quantity" requested.

<u>IDPA Envelope Number</u>	<u>QUANTITY</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FOR IDPA USE ONLY

(Provider Number is Required)

PROVIDER NUMBER _____ PROVIDER TYPE _____

Attention _____

PROVIDER NAME _____

Street Address (cannot deliver to Post Office box) _____

City _____

State _____

Zip _____

GENERAL APPENDIX 11

MANAGED CARE ORGANIZATION (MCO) CONTRACTORS

COOK COUNTY

Amerigroup Illinois, Inc.

211 W. Wacker Drive, Suite 1350
Chicago, Illinois 60606
Telephone (312) 214-0400
Fax (312) 214-0424
Member Services (800) 600-4441

Harmony Health Plan

125 South Wacker Drive, Suite 2600
Chicago, Illinois 60606
Telephone (312) 630-2025
Fax (312) 368-1784
Member Services (800) 608-8158

Family Health Network

910 West Van Buren, 6th Floor
Chicago, Illinois 60607
Telephone (312) 491-1956
Fax (312) 491-1175
Member Services (888) 346-4968

MADISON, PERRY, RANDOLPH, ST. CLAIR AND WASHINGTON COUNTIES

Harmony Health Plan

23 Public Square, Suite 340
Belleville, Illinois 62220
Telephone (618) 236-8050
Fax (618) 233-3621
Member Services (800) 608-8158

GENERAL APPENDIX 12**COST-SHARING FOR ALL KIDS AND FAMILY CARE
SHARE AND PREMIUM**

Benefit	Cost-Sharing *	
	Share	Premium Level 1
Inpatient hospital services	\$2/admission	\$5/admission
Emergency hospital services	\$2/visit	\$5/visit OR \$25/visit when emergency room is used for non- emergency reason
Outpatient hospital services	\$2/visit	\$5/visit
Physician services	\$2/visit	\$5/visit
Clinic services	\$2/visit	\$5/visit
Prescription drugs	\$2/Prescription (1-30 day supply)	\$3/Generic OR \$5/Brand Name Prescription (1-30 day supply)
Over-the-counter (OTC) medications (Coverage for OTC medications for adults age 21 and over is limited to smoking cessation, diabetic supplies and insulin.)	\$2/Prescription (1-30 day supply) covered only when prescribed	\$3/Generic OR \$5/Brand Name Prescription (1-30 day supply) covered only when prescribed
Outpatient laboratory and radiology services (hospital based or independent)	\$0	\$0
Prenatal care	\$0	\$0
Family planning services	\$2/Visit	\$5/Visit

Benefit	Cost-Sharing *	
	Share	Premium Level 1
Inpatient mental health services	\$2/Admission	\$5/Admission
Outpatient mental health services	\$2/Visit	\$5/Visit
Inpatient substance abuse treatment services	\$2/Admission	\$5/Admission
Residential substance abuse treatment services	\$2/Admission	\$5/Admission
Outpatient substance abuse treatment services	\$2/Visit	\$5/Visit
Durable medical equipment	\$0	\$0
Disposable medical supplies	\$0	\$0
Preventive dental services	\$0	\$0
Restorative dental services	\$2/Visit	\$5/Visit
Hearing screening	\$0	\$0
Vision screening	\$0	\$0
Optometric services	\$2/Visit	\$5/Visit
Corrective lenses (including eyeglasses)	\$0	\$0
Immunizations	\$0	\$0
Well-baby visits	\$0	\$0
Well-child visits	\$0	\$0
Early Intervention services	\$0	\$0
Emergency medical transportation	\$0	\$0
Non-emergency medical transportation	\$0	\$0

Benefit	Cost-Sharing *	
	Share	Premium Level 1
Physical therapy	\$0	\$0
Speech therapy	\$0	\$0
Occupational therapy	\$0	\$0
Physical rehabilitation services (hospital based)	\$0	\$0
Advanced Practice Nurses	\$2/Visit	\$5/Visit
Podiatric services	\$2/Visit	\$5/Visit
Chiropractic services	\$2/Visit	\$5/Visit
Audiology	\$0	\$0
Home health care services	\$2/Visit	\$5/Visit
Nursing facility	\$0	\$0
ICF/MR	\$0	\$0
Hospice care	\$0	\$0
Private-duty nursing	\$2/Visit	\$5/Visit
EPSDT not otherwise listed above	\$0	\$0

* Cost Sharing - No copayments are required for preventive or diagnostic services. The annual copayment maximum per family is \$100. Families with children who are of American Indian or Alaska Native ancestry may not be charged a copayment.

GENERAL APPENDIX 13**COST-SHARING FOR CHILDREN ENROLLED IN ALL KIDS EXPANSION**

	Premium Level 2	Premium Level 3	Premium Level 4	Premium Level 5	Premium Level 6	Premium Level 7	Premium Level 8
CPT Codes 99201 – 99215	\$10/visit	\$15/visit	\$20/visit	\$25/visit	\$25/visit	\$25/visit	\$25/visit
CPT Codes 99241 – 99245	\$10/visit	\$15/visit	\$20/visit	\$25/visit	\$25/visit	\$25/visit	\$25/visit
CPT Codes 90801 – 90911	\$10/visit	\$15/visit	\$20/visit	\$25/visit	\$25/visit	\$25/visit	\$25/visit
CPT Codes 92002 – 92015	\$10/visit	\$15/visit	\$20/visit	\$25/visit	\$25/visit	\$25/visit	\$25/visit
CPT Codes 98940 – 98943	\$10/visit	\$15/visit	\$20/visit	\$25/visit	\$25/visit	\$25/visit	\$25/visit
T1015 (Per Billable Encounter)	\$10	\$15	\$20	\$25	\$25	\$25	\$25
Restorative Dental	\$10/visit	\$15/visit	\$20/visit	\$25/visit	\$25/visit	\$25/visit	\$25/visit
Prescription Drugs Including insulin and diabetic supplies. (Per 30-day supply)	Brand \$7 Generic \$3	Brand \$14 Generic \$6	Brand \$21 Generic \$9	Brand \$28 Generic \$12	Brand \$28 Generic \$12	Brand \$28 Generic \$12	Brand \$28 Generic \$12
Emergency Room Visit	\$30	\$50	\$75	\$100	\$100	\$100	\$100
Hospital Admission (Including admissions for substance abuse and mental health services)	\$100	\$150	\$200	10% of HFS rate per admission	10% of HFS rate per admission	10% of HFS rate per admission	25% of HFS rate per admission
Outpatient Services % of HFS rate paid for each outpatient service	5%	10%	15%	20%	20%	20%	25%
Annual Copayment Maximum	\$500 per child for hospital services	\$750 per child for hospital services	\$1,000 per child for hospital services	\$5,000 per child for hospital services	\$5,000 per child for hospital services	\$5,000 per child for hospital services	No Maximum

**COPAYMENT PROCEDURE CODES FOR TITLE 19
PARTICIPANTS AGE 19 AND OLDER**

Code	Description
92002	General Ophthalmologic Services
92004	General Ophthalmologic Services
92012	General Ophthalmologic Services
92014	General Ophthalmologic Services
92015	General Ophthalmologic Services
98940	Chiropractic Manipulative Treatment
98941	Chiropractic Manipulative Treatment
98942	Chiropractic Manipulative Treatment
98943	Chiropractic Manipulative Treatment
99201	Office visit, new
99202	Office visit, new
99203	Office visit, new
99204	Office visit, new
99205	Office visit, new
99211	Office visit, est.
99212	Office visit, est.
99213	Office visit, est.
99214	Office visit, est.
99215	Office visit, est.
99241	Office Consult, est.
99242	Office Consult, est.
99243	Office Consult, est.
99244	Office Consult, est.
99245	Office Consult, est.

For information on excluded patient populations and services, refer to 89 III. Adm. Code 140.402.